

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-001058

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 128Primary Registration District No. 2000Registrar's No. 147

FILED JAN 30 1963

VS 300
Rev. 4/59

0397

2140

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Wright</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		c. CITY OR TOWN <u>Mansfield</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Burge Protestant</u>		d. STREET ADDRESS (If outside, give location) <u></u>	
3. NAME OF DECEASED (Type or print) First <u>Naomi</u> Middle <u>Jane</u> Last <u>Blazer</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>24</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-28-1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11a. FATHER'S NAME <u>Andrew Ross</u>		11b. MOTHER'S MAIDEN NAME <u>Marjorie Newton</u>	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		12b. SOCIAL SECURITY NO. <u></u>	
13. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration - Malnutrition</u> DUE TO (b) <u>Cachexia</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Congestive Heart Failure</u>		14. NAME OF HUSBAND OR WIFE <u>Horace M.</u> 15. ADDRESS <u>Mrs Paul Hunsaker, Stanford, Ky.</u> 16. INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a.m. <u></u> p.m. <u></u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u>	
21. I attended the deceased from <u>24 Jan 63</u> to <u>24 Jan 63</u> and last saw him/her alive on <u>2 PM</u>		22. ADDRESS <u>Springfield Mo</u>	
22a. SIGNATURE (Degree or title) <u>J. Watersfield</u>		22c. DATE SIGNED <u>1-28-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Jan 24, 1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Newton</u>		23d. LOCATION (City, town, or county) <u>Wright county Mo.</u>	
24. FUNERAL DIRECTOR <u>Max L Miller</u>		25. DATE RECD. BY LOCAL REG. <u>1-29-63</u>	
26. ADDRESS <u>Mansfield, Mo.</u>		26. REGISTRAR'S SIGNATURE <u>Effie E. Meelton</u>	

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Max L. Miller

Licensed Embalmer No.

4720

P. O. Address

Mansfield Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.